IN THE UNITED STATES DISTRICT COURT FOR THE

NORTHERN DISTRICT OF OKLAHOMA

DEBORAH YOUNG, as Personal Representative of the Estate of Gwendolyn Young, deceased,	)	
Plaintiff,	)	
-vs-	)	No. 13-CV-315-IDJ-JFJ
CORRECTIONAL HEALTH CARE COMPANIES, INC.,	)	
Defendant.	)	

TRANSCRIPT OF JURY TRIAL CLOSING ARGUMENTS

BEFORE THE HONORABLE IAIN D. JOHNSTON

UNITED STATES DISTRICT JUDGE

FEBRUARY 23, 2023

REPORTED BY: BRIAN P. NEIL, RMR-CRR
United States Court Reporter

A P P E A R A N C E S

Daniel E. Smolen, Robert Blakemore, and Bryon D. Helm, Attorneys at Law, Smolen & Roytman, 701 South Cincinnati Avenue, Oklahoma, 74119, attorneys on behalf of the Plaintiff;

Sean P. Snider and Anthony C. Winter, Attorneys at Law, Johnson, Hanan & Vosler, 9801 North Broadway Extension, Oklahoma City, Oklahoma, 73114, attorneys on behalf of Defendant CHC;

Ronald W. Chapman, Sr., Attorney at Law, Chapman Law Group, 1441 West Long Lake Road, Suite 310, Troy, Michigan, 48098, attorney on behalf of Defendant CHC.

I N D E X

Thursday, February 23, 2023

* * * * *

(Jury enters the courtroom)

THE COURT: Good morning. Have a seat.

I apologize for the delay. We were getting some things finalized. We're at the beginning of the end. So if you remember a week and a half ago when I gave you sort of how things are going to flow, we're done with the evidence. There's some documents you're going to get that you really didn't see but you'll get those to take back to the jury room. So we're going to have closing arguments at this point.

So, if you recall, the plaintiff has the burden of proof so they get to start, defense responds, and then plaintiff gets rebuttal at the last word. I think how it will shake out with timing is, we'll hear from Mr. Smolen, probably break for lunch, then we'll hear from Mr. Chapman -- right, Mr. Chapman, you're doing closing?

MR. CHAPMAN: Yes, Your Honor.

THE COURT: -- Mr. Chapman, then we'll hear from Mr. Smolen again, and then I've got jury instructions that I'll read to you. You'll get copies, your own copies, so you can follow along. Back in the day you didn't get these things; you had to remember them. It was nuts. So you'll get the instructions. I'll give you the instructions. You'll go back and you can start deliberations, okay? So we're almost there.

All right. So, Mr. Smolen, whenever you're ready to proceed, let me know.

MR. SMOLEN: Thank you, Your Honor.

Charlie, I want to go ahead and pull up for the jury the jury instruction 14. First off, I want to tell you guys I'm really, really appreciative of the time that you spent taking out of your lives listening to the evidence in this case. It's a lot of evidence. We're going to have an opportunity to have a closing that allows me to go through some of it. You've been taking notes the whole time. I think you understand the importance of the evidence.

I really want to tie it initially, before I start the closing, to the jury instruction 14, and I specifically want you guys to take a look at, if you would -- what this jury instruction is, it's about the elements, the definitions, and the policies of deliberate indifference of constitutional violations and how they happen and what you have to establish to have that, okay? It's a really important instruction and I want you first just to look at the definition of the term "deliberate indifference."

Charlie, would you highlight that for the jury, please? Right below that, Charlie, where it says -- yep, there you go.

"'Deliberate indifference' means a knowing disregard of an excessive risk to an inmate's health or safety, including preventing an inmate from receiving treatment or denying an

inmate access to those able to evaluate the need for medical care. Knowledge may be inferred from circumstantial evidence, including the following examples:

"obviousness of the risk;

"the delay in providing medical treatment that causes pain or a worsening of the inmate's condition, or.

"the continuation of a course of treatment that the medical professional knows to be ineffective."

That's the definition of "deliberate indifference." That's what we're looking at. That's the evidence that we've been presenting for the last two weeks.

Specifically, as it pertains to Gwendolyn Young, we've identified and you'll see --

If you will, Charlie, on page 15 for the jury's benefit.

There's bullet points. And these are really, really important that you guys understand the way that the law works. These instructions, they've been put together and they're incredibly clear and really, really straightforward. But I want you to understand that in this case what we're alleging is that CHC, Correctional Health Care Companies, follows customs, policies, and practices that deny a person their constitutional rights to adequate health care.

The specific policies that we're talking about being the moving force behind that are these that we've identified in

the jury instruction:

"A systemic failure of medical policies and procedures;

"A pattern of failures to provide medical care in response to serious and obvious medical needs of inmates;

"Failing to provide adequate training and supervision regarding emergent medical conditions;

"Continuing to adhere to a deficient system of care for inmates with serious medical needs;

"A pattern of failures to provide inmates with sufficient access to a physician; and" lastly,

"A pattern of failures to send inmates with obvious and emergent needs to a hospital."

We only have to establish one of those, but the evidence in this case is overwhelming that all of those have been met. And I want to walk you through each one of those specific motivating, moving forces that brought about Ms. Young's constitutional violations.

Charlie, if you would, I want to just pull up slide 1.

So what I've done is just for the purposes of the closing, to make sure that everyone understands the way that the jury instruction works, I've put together an outline and we're going to go through it. Each one of those policies, customs, or practices intersect through the death of Gwendolyn Young. They also connect all the other deaths that we've talked about over the last eight days.

I want to first look at -- you see here we've got pattern of failure to send inmate with obvious and urgent needs to the hospital, failing to provide adequate training, systemic failures in medical policies and procedures, pattern of failure to provide medical care, continuing to adhere to a deficient system, and a pattern of failures to provide inmates with sufficient access to a physician.

I want to start by looking at the pattern of failures -- this is slide 2 -- the pattern of failures to send an inmate with obvious and emergent needs to the hospital. I want to talk about it in the context of their knowing disregard. When I first started doing this, I used to get really confused and I've seen the term attempted to be confused by opposing counsel at times during litigation, and it's this idea that what is deliberate indifference? It's really to just know of a risk and disregard it. It's really that simple.

But when we talk about it in the context of a Monell claim -- you've heard that term perhaps during the trial -- we're talking about all of these policies and procedures and how they become a moving force behind the systemic deaths that were happening in this facility.

So when we look at it, a pattern of obvious failures to send inmates with obvious and emergent needs to the hospital, I want to show you, just kind of going back through the evidence, of what evidence was presented that establishes that particular

motivating force.

If you'll look at slide 3. In Plaintiff's Exhibit 1, which is Dr. Roemer's report, on pages 2 and 3, there were two inmates that Dr. Roemer identified during the audit process, one was Linda Henshaw and the other was Damien Tucker, that really relate to the concept of a pattern of failures to send inmates with obvious and emergent needs to the hospital.

When Dr. Roemer conducted his audit on the 2010 deaths, what he found was that pertaining to Linda Henshaw that she had a blood pressure of 94/60 between 7:00 a.m. and 7:00 p.m. He also found that at 5:30 the inmate has a cardiac arrest and is eventually pronounced dead at the scene.

This is another situation where a person's blood pressure is dangerously low. Between 7:00 a.m. and 7:00 p.m. on the previous date, the blood pressure was measured dangerously low. No one does anything for Ms. Henshaw. She remains in the jail, she's not transported to the hospital emergently, and she dies.

Same thing with Damien Tucker in 2010. March 12th of 2010, an inmate was found to have an altered level of consciousness and breathing difficulties. At 12:12, medical staff arrived. Chest pain over the past week was also reported. Dr. Adusei appeared to be notified -- time is unclear -- and arrived around 12:25. There was a 42-minute delay in calling EMSA. An inmate with his clinical findings at

12:03 would certainly have chances for survival optimized with a prompt 911 call and a hospital transport.

That is more evidence going back to the 2010 time frame, three years before Ms. Young dies, that CHC has notice that they're not getting people to the hospital in a timely fashion based on their obvious medical -- their serious obvious medical conditions, dangerously low blood pressure, chest pain for a week, altered mental state, altered consciousness. They don't transport them.

Dr. Roemer is identifying this, he's sharing it with the Tulsa County Sheriff's Office, and that information's being shared with CHC all the way back to 2010.

The NCCHC requirements that you guys have heard about in this case, they require emergent transport under these conditions of an inmate to an outside facility so that they can get diagnostic testing and they can get a heightened level of care, where a dangerous condition, like a subdural hematoma, like a stroke, like a heart attack can actually be diagnosed. They don't have the capabilities to do it in the jail. And so that's what we're talking about here.

I want to look at some more evidence that pertains to CHC's pattern and practice of failing to send inmates with obvious and emergent needs to the hospital.

Next slide.

On October the 27th, 2011, Elliott Williams died in the

Tulsa County Jail. You guys watched the video. You'll have an opportunity to watch the video when you go back and deliberate. It's Plaintiff's Exhibit 67.

When I first saw the Elliott Williams video, it was very, very disturbing for me, so disturbing that it changed -- literally changed the course of the work that I was doing. I don't know how you can watch that video and forget what was on it, like Chris Rogers did, and she was the person that was in charge. I'll never forget that video.

That's more evidence in October of 2011 of just a total, total disregard. You've got a person that's been drug on a blanket covered in feces and urine into his cell for the purposes of proving that they're faking paralysis, even though they've been telling medical staff for over 12 hours that they broke their neck and they can't move. They're begging for water, he's begging for a pitcher of water, and they drag him into his cell, and they put a cup of water out of his reach to try to make him move, to go get it. They don't do any examination at all.

One of the questions that was asked by the jury -- it was a really, really good question -- to Dr. Adusei, I think is who it was, what's a cursory examination? Like what does that even mean? There's no such thing as a cursory examination. When they talk about it -- and we'll talk about this later -- it's, oh, we just pop in and take a look at them, ask them how

they're doing.

We see a cursory examination in Plaintiff's Exhibit 67 when Dr. Harnish walks into that cell as Mr. Williams is on the floor begging for help, begging to be sent to a hospital, begging for water, and he just stairs at him, flips the blanket over him so he doesn't see his private parts, walks out, and says, let's just continue to monitor him in a video-monitored cell.

No vitals were taken. Despite the evidence that they said they had been, no vitals were taken. Mr. Williams proceeds to lay there for 52 hours trying to put his hand in a cup of water so he can drip some water into his mouth. But, hey, he could still move his arm. How were they to know? That's the defense, that that's somehow not deliberate indifference. It's an absurd argument.

Chris Rogers sat here and said, oh, the care was really inappropriate, it was really bad. In 2015, she testified under oath she didn't have a problem with it. I don't know how you can watch that, be responsible for this human being, and not only not remember the video, okay, but to sit here and lie to the jury about your view of the appropriateness of the care. I think that it's shocking.

When you see -- if you go back -- we hit on it during the presentation of the evidence -- but if you go back -- I promise you if you go back and watch this video, it will change

your life when it comes to the way you view Correctional Health Care. It just will. And to watch them roll him off the blanket while they're supposedly performing resuscitative efforts, to watch them rip a blanket up, roll his dead body across the floor, come back, and then kick it over with his foot, and then start the CPR process again.

That's the elements that we're talking about when we're talking about CHC's pattern and practice of failing to send inmates with obvious and emergent needs to the hospital. It goes to knowledge. It goes to continued indifference. They're already put on notice about this.

When they begin contracting with the county in 2005, they had to guarantee -- one of the things we didn't get into, but you guys are going to have an opportunity to look at it during your deliberations, were the county contracts, okay, that existed between CHC and the Tulsa County Sheriff's Office and the county.

What's really, really important that you understand is, when they agreed to contract to provide medical care to people in Tulsa County, they acknowledged that they were bound by NCCHC standards and guidelines. They already knew what they were required to do. They've known the entire time. It wasn't uncovered until about the 2009-2010 time frame and people started to catch on to what was happening. Inmates started to die at high rates in the Tulsa County Jail and people really

started to look into it.

We talked about Brian Edwards looking into it; Dr. Roemer doing the audit; Josh Turley, the head of risk management, participating in that process. That's when you first start to really learn about all the deaths, but that's when the county started to learn about it. CHC was supposed to do mortality reviews. They were required to -- and we're going to get into that -- they were required to do a lot of things, but there's no doubt they had knowledge of what was going on in the facility in 2005 all the way forward, okay?

Let's go to the next slide.

Dr. Allen, the only physician to testify about the care and the type of conditions that existed in the jail. That was the only witness that testified about that. You had Nurse Harrington talking about factually what she observed. You had Dr. Adusei talking about his factual -- his actual day-to-day. But as far as looking at it from a system-wide level, Dr. Allen was the only person that ever testified about that.

And we've got here a photograph of Lisa Selgado and in the middle Gregory Brown and on the right Gwendolyn Young. I think this is important when we're looking at it in the context of sending inmates or not sending inmates to the hospital who have obvious and emergent needs. Here's what Dr. Allen said.

I asked him, "I want you to tell the jury what, if any, similar problems that you found between the deaths of

Ms. Selgado, Ms. Young, and Mr. Brown that you felt like, if at all, were present in those three individual reviews."

And his answer, "The most significant crosscutting feature in those medical cases was the fact that in all three cases, the patients met multiple criteria for immediate referral and transfer to an emergency room but it did not happen."

That was the same for Elliott Williams. That was the same for Damien Tucker. That was the same for Linda Henshaw. It was a crosscut, a moving force behind all of their deaths. That's just one thing that I can show establishes liability in this case.

Six real quick, if you would.

So Roemer's review -- it's Plaintiff's Exhibit 1, okay -- you will go back, if you want to, and look at that and you'll see where he pulls out of their medical charts. This is his findings. This is how he knows independently, right? He's different than Dr. Allen. He's different than all these other people. He's in there doing an independent audit for TCSO and the county. He starts to heavily document.

Let's look at slide 7, Charlie.

This is like just damning evidence of knowledge and indifference, okay, is Plaintiff's Exhibit 65, pages 1, paragraph 3, which references the criteria for immediate referral to a hospital.

The reason it's so damning is because, one, it's just a reiteration of the NCCHC standards that they had already contractually agreed to do in 2005. But in the language of Dr. Herr's letter to the Tulsa County Sheriff's Office, under criteria for immediate referral --

Charlie, will you highlight that in the box, please, and then right underneath that.

You guys heard a lot about it. I talked about it in the opening because it really is -- it's a backbone to understanding liability in this case. Because we got to show, one, that they knew there was a risk, right; and two, that they ignored the risk to inmates like Ms. Young. That's what we're looking at.

In their very own language that they put into the criteria for immediate referral, it says, "The following is a list which is not meant to be exclusive of abnormal vital signs and medical conditions that are generally not acceptable for ongoing care in jail or prison setting and require emergent transfer to the nearest emergency department."

That is evidence, direct evidence, of CHC's knowledge that those conditions identified on this list are not appropriate to continue to house in a correctional setting, that you have to move those people out because you have to get diagnostic in, you have to get a real evaluation by a physician in. That's why they had to do it. They were supposed to be

doing it from 2005 forward. This is a reiteration, a recommitment of what had already been promised.

The Tulsa County Sheriff's Office made them put it in writing based on what the audit findings show, the 2010 NCCHC audit, 2011 ICE audits, Dr. Roemer's continued work that he was doing. CHC, on behalf of Dr. Herr, says, look, we agree, all of these conditions are really not appropriate to continue to house somebody in a correctional setting.

Gwendolyn Young met three of them during her incarceration. Her systolic blood pressure was measured two times below a hundred. Never sent.

Five, chest pain that is possibly ischemic in nature. If you look at Plaintiff's Exhibit 44, check out -- I think it's in January or late January -- she's having chest pain. They don't follow it. They don't send her out. They just completely disregard the protocol. That is just continued evidence of deliberate indifference of a known emergent medical need that they're not sending out for additional care.

Eight, delirium that is felt to be medical in nature. According to jail staff, who didn't even know her that well, they're saying that this is not the person that we're used to housing. If everything was okay, she'd be up cussing at us. But she's laid on the floor for four days. She's been vomiting blood. She had a blood pressure of 80. And no one's doing anything to help her. All they had to do -- all anyone had to

do was follow a half-page instruction that the defendant put in place because none of the staff had been doing it before. So let's make it real simple, let's put it on half a page so that no one can screw this up. Blood pressure below a hundred, get them out. Delirium that's believed to be medical in nature, get about them out. Chest pains, shortness of breath, get them out. They don't do it. They don't do it despite knowing everything they know prior to March 23rd of 2012 when they make this promise.

After they make the promise, here's what Dr. Roemer continues to find. If you go down the timeline, the timeline is really important in this case.

Look at slide 8, Charlie.

So this is a continued audit from April the 16th, okay? It's auditing charts, random audits of inmates that had been booked into the facility in April, a month after CHC had made the promise that they made, okay, based on everything they knew. Here's what Dr. Roemer found.

Overall the audits demonstrated deficiencies. Several, three and eight, are of major concern as they involve high-risk.

I asked, "What's your understanding of whether or not CHC was meeting the requirements that they had stated in March?" And I asked this of the Tulsa County Sheriff's Office risk manager.

His answer was, "I don't believe that they were meeting what they had told us that they were going to do."

And I asked him, "And with respect, what did he find on the 4/16 audit in the first sentence? He states it in there.

He answers, "The 4/16 audit could not identify actual occurrence where staff complied with the policy. The above episodes are of major concern for potential of the system to allow serious adverse outcomes. This should be cause to generate immediate systems of improvement."

A month after they were promised, again, we're going to do these very simple things, Howard Roamer is finding that across the board they are not.

I want to go to the next slide, 9. Let me know when you're there, Charlie.

This is an excerpt from Dr. Allen's testimony during the trial. You guys don't get the benefit to go back there with the trial transcript and read it all so I want to point out some things that were really critical in the testimony.

"So you've talked to the jury what you found so far up through the 7th. Do you believe it is reckless at this point for Ms. Young not to have been sent to a hospital?

"ANSWER: Yes.

"Do you believe it's dangerous to continue to house her?

"ANSWER: Absolutely.

"QUESTION: And does that fall below the standard of care for providing constitutionally sound adequate care in a jail facility?

"ANSWER: Yes."

That's the only expert who's testified in this case about the standards in correctional settings, Dr. Allen. He is the leading expert in the entire country on correctional health care.

Let's look at the next slide.

Going back to Ms. Young, the way all of this kind of intersects through her life and her untimely death. Dr. Allen testified, "At 6:51 on February the 8th of 2013 in the SHU, the detention staff called medical at 6:48 telling them that Ms. Young is complaining of difficulty breathing. They stated they were sending a nurse to assess her now.

"QUESTION: With all Ms. Young's other complaints that we've talked about up until this point and her other symptoms that had been identified, what, if anything, does a complaint of difficulty breathing or shortness of breath tell you as a physician?"

He answered, "Again, in a picture that is already abundantly clear to a clinician, that she is deteriorating and well past the line of needing care in an emergency room, we now have the additional symptom of difficulty breathing. We're now seeing multiple organ system complaints, not just a focal

complaint in one system, and that's not a good sign."

She should have been sent to the hospital seven days before. They could have sent her on the 4th. They were required to send her on the 4th. Her body continues to die slowly over time and no one does anything for her, just like Elliott Williams, just like Damien Tucker, just like Linda Henshaw, just like all of the people that Dr. Roemer identified, just like Lisa Selgado, same physician, Dr. Washburn. Same guy who said, hey, it was my bad when he was asked to go check on Williams and didn't go.

He's the same guy that didn't go check on Lisa Selgado when she was in cardiac arrest and had been vomiting for days and was severely dehydrated. When her body was found, she was modeled and cyanotic, cold to the touch. But Nurse Metcalf came in and she fixed the vital signs like she had done time and time and time again. She did it in front of nursing students. How crazy is that? Like that is absolutely insane that that was happening in our jail.

I want to look at slide 14, Charlie.

This idea of faking, this idea of we're not going to send then to the hospital because they're faking, it is so wrong on so many levels, okay? Because these people, they can't get to a hospital, they can't just walk into a hospital. They know what's going on with their own bodies. They're telling everybody something is really, really wrong, and they

just are ignored.

We have Nurse White in front of the detention staff, she's faking her injury. She's been vomiting for days. She can't get off the floor. She can't breathe. And this lady has the audacity -- and I tried to get her here. She dodged service for 16 weeks.

MR. CHAPMAN: Objection, Your Honor.

THE COURT: Sustained.

MR. SMOLEN: I want you to hear from everyone. I did my best to get them all here in the time that I was allotted --

MR. CHAPMAN: Objection, Your Honor.

THE COURT: Sustained.

MR. SMOLEN: Let's look at what Dr. Allen had to say about Ms. Young. I asked him, "Okay. Was this an appropriate response by Nurse White?"

He asked me, "Was what an appropriate response?

"QUESTION: Taking her back to the SHU after all of these things that she's observed in the medical unit, was that an appropriate medical response?

"ANSWER: So no. And I would add, though, that there's now the involvement of Dr. Adusei. So Dr. Adusei at this point, the decision to send her back to the special housing unit or segregated housing unit without having a done a proper evaluation is very problematic. But the nurses do have

some responsibility if they feel that someone who is above them is not doing the right thing to advocate for their patient. All of us in health care, regardless of our licensure or rank, have a duty to advocate if someone appears to be making a very dangerous decision. That's on teams. We call that sort of the duty to worn. Anyone on the team, regardless of rank, can say, hold on, I'm worried about this. Are you sure you've considered this? That kind of advocacy is routine in medical teams."

There was absolutely no advocacy for Ms. Young by anybody with CHC.

Let's go to slide 16, please.

And this is the last thing because we're still under the first prong of just one of those elements that we can show, okay? I want to try to get to the rest of them in the amount of time that I have. I could talk to you guys about this for days but we've got a limited amount.

I asked Dr. Allen during the trial, "Do you believe at this point in time, based on your review of the records, the video, all of the statements, all of the materials that you've reviewed, that even at 8:05 in the morning, do you have an opinion as to whether or not Ms. Young, if she had been taken to the hospital even at this late point in time, would have been able to survive this event?

"ANSWER: I think she had a good -- very good chance

of surviving had she received the intervention that she needed."

"Okay. And would you state that to reasonable degree of medical certainty?

"ANSWER: Yes."

That's absolutely consistent with what the medical examiner testified, too, that these are survivable events if you get a person to a hospital, let it get diagnosed, and do treatment, treatment that you can't provide in the Tulsa County Jail in a medical clinic.

All right. Let's look at 17.

I want to touch on another component of liability under the deliberate indifference standard. That's failing to provide adequate training and supervision regarding emergent medical conditions.

Let's look at 18.

And this is wrong on the slide, guys. It's PX 35, which is Karen Metcalf's disciplinary records. It's her personal file, okay? That piece of evidence is critical to understanding this component, this thread of deliberate indifference.

I asked her, "I asked you while you were under oath in your deposition, line 13, overall was your supervisors satisfied with your employment when you worked at the jail?"

"And what was your answer at line 19?"

"Yes. Because I didn't get fired so I thought it was okay."

She's routinely falsifying medical charts. She's routinely leaving the medical clinic and disappearing for 20 to 30 minutes at a time. There are probably a dozen write-ups in her file. Look at all of them. I'll bet you two-thirds of them aren't signed. And why weren't they signed? Well, Chris Rogers told us. Because those disciplinary reports had been sent to CHC corporate executives and they chose not to discipline her.

That is an affirmation that what you're doing is okay when you're hands-on supervisors, your direct supervisors, at the facility are wanting to write you up because you're violating every policy and procedure, you're unable to figure it out, your care is dangerous to the inmates and to your patients, right, and then corporate says, hey, we're not going to write her up. That sends a message that the behavior's okay. That's failing to provide adequate training and supervision.

Then not only to not administer the discipline, but to give her a positive job evaluation during the same time frame that four or five inmates died that she was responsible for their care, that's absolutely nuts. But that's what happened.

I want to look at another element, Charlie, on slide 19.

Systemic failure of medical policies and procedures. It's another component of liability. Again, I know you guys took great notes. You were incredibly receptive the whole time. But just putting those notes into the right categories, I want you guys to understand how it works. This is another individual line of liability. Again, if we just establish this line, it's a verdict for the plaintiff, okay, a systemic failure of medical policies and procedures.

I think this is probably one of the best statements that came out during testimony because it was with Chris Rogers on the stand. I think it was Friday before we took a weekend break. It's the one thing that I absolutely agreed with her on, okay? No question about it. We do not agree on a lot of things but she and I agree on this. Look at her testimony from Friday before we had the weekend break.

I asked her, "Who do you think is responsible for Mr. Williams' death?"

And her answer, "Responsible? I think the whole system."

She's absolutely right. It was a complete systemic failure across the board. But what's so sad about it is that she only acknowledged that after multiple depositions, after me putting her on the stand having to get it out of her, okay? That's -- you're watching indifference when you see that. Like that is indifference in the courtroom. You don't have to go

back and try to figure out whether or not the person was indifferent; she acknowledges it here finally, okay?

But what's so sad about it is that like just because they videotaped his death, that's now the -- like we know what happened to him, right, because it was videotaped for five days. But there's so many people who have died in this facility where there's not a videotape of their death so you're having to kind of reconstruct it based on falsified medical records.

I think it's just really sad that people -- I think what happened to Mr. Williams is incredibly sad and wrong and disgusting and torture, okay? But there are other people like Ms. Young, okay? I don't see any difference between the way Ms. Young died and the way Mr. Williams died other than the fact that she was in a nonvideo-monitored cell, right? If she had been in cell No. 1, where Williams was housed, you guys would have video of her laying on the floor for four days, unable to get up, with him wanting to drag her around on a blanket --

MR. CHAPMAN: Objection, Your Honor. There's no evidence of that.

THE COURT: Sustained. Sustained.

MR. SMOLEN: There is evidence that they sought to drag her on a blanket. It's in Plaintiff's Exhibit 41. And it's when the Tulsa County Sheriff's Office say, huh-huh,

you're not going to drag Ms. Young on a blanket. You're going to pick her up and you're going to put her on a gurney. Because they know what happened to Mr. Williams just 18 months before. That's why they stopped them. But it was the medical's decision to drag her on and a blanket. It's in writing, Plaintiff's Exhibit 41.

Let's look at -- we can look at 21 real quick, Charlie.

Again, Dr. Allen testified to the point of CHC's systemic failure of medical policies and procedures. "The key thing is, I think, with all of these points we've gotten to, you don't need to diagnose. It's nice if you can. But here's the point. You can't diagnose these conditions a lot of them that we're considering about where we are. That's why the protocols are all built around -- our practices are all built around recognizing when someone is too sick to be in your facility and to get them to a hospital."

Again, it's the same thing we're talking about, right, plaintiff's Exhibit 65. They acknowledge it. Dr. Allen's talking about it. All the audits are pointing to it. They were well aware of the situation.

Let's look -- because we did hear about the NCCHC stuff even though Dr. Adusei had never heard of it. I mean, that's the medical director, right, that had never heard of NCCHC. Like that's crazy.

But let's look at slide 23.

Because I want to show you guys some of those NCCHC standards. You'll find this in Plaintiff's Exhibit 36. There was a long day of like reading this stuff into the record by defense counsel and he was talking about, well, that didn't really apply here, that didn't really apply there. Let me show the ones -- a lot of them applied but some the primary ones are here.

Man down drills was when a person was down, when they were sick, right, when they couldn't get up. They had nothing in place. The compliant -- it wasn't met. The standard wasn't met, right, J-A-07. But look at J-A-10. This one is really shocking because this is a NCCHC standard that they were aware of since 2005, okay?

It says, "There have been several inmate deaths" -- and I'm reading on the right-hand side.

You got it? Thanks, Charlie.

"There have been several inmate deaths in the past year. In March 2010, deaths were related to pulmonary embolism, suicide, and unknown cause. There was no psychological autopsy for the suicide. The clinical mortality reviews were poorly performed. In June 2010, there was a death due to natural causes. No death review was conducted. The standard is not met."

What's really important about the mortality reviews is it's because it's what CHC is supposed to be doing every time

they have an inmate that dies in the facility. And if you'll look at the corrective action, right, this is, again, a note from a 2010 NCCHC report to CHC saying here's the corrective action that was required. Again, this is before Lisa Selgado dies, Gregory Brown dies, Gwendolyn Young dies. All of this is before they die, okay?

"All deaths should be reviewed within 30 days. The death review should consist of an administrative review, clinical mortality review, and psychological autopsy if the death is by suicide. The clinical mortality review is an assessment of the clinical care provided and the circumstances leading up to the death. Its purpose is to identify areas of patient care or system policies and procedures that can be improved and it should be included in the death review.

"As the psychological autopsy is a written reconstruction of an individual's life with an emphasis on factors that may have contributed to the death, it should also be a component of the overall death review. That occurs within 30 days in cases of suicide.

"The following is acceptable documentation" --

THE COURT: Slow down a little bit.

MR. SMOLEN: -- "for compliance."

The RHA, okay, resident health authority; Chris Rogers, the HSA; the director of medical, Dr. Adusei or Dr. Washburn, should submit to NCCHC an action plan that describes how this

standard will be corrected. Specifically, any necessary policy or procedure change to ensure that all three components of death reviews, including the psychological autopsy in the case of suicide and the clinical mortality review, are conducted within 30 days of the death.

The reason that they're doing that and that they're requiring that -- and that's always been required -- is because when you go and you do a mortality review on any of the individuals that Dr. Roemer identified or Dr. Allen identified, you will identify the systemic failures that led to that death. That's why they're doing it.

And there's a reason why Chris Rogers or an HSA or the medical director is required to be involved, so they can't come and say, well, I don't know how that one went down. I don't really remember that one. It goes to notice. They have a constitutional right to know. You can't just put your head in a hole and say, well, I never looked at the mortality reviews so I didn't know why all these people were dying so I really didn't know.

That's not the way it works. You should have known, you were required to know, the guidelines require you to make yourself knowledgeable about what happened so you can prevent it from happening in the future, and that never happened.

Let's look at slide 24.

This is another line of liability. Pattern of failures

to provide medical care in response to serious and obvious medical needs of inmates. Just real quickly, I want --these, again, are identified by Dr. Roemer, Plaintiff's Exhibit 1, page 5.

Slide 25, if you would, Charlie.

According to CHC policy 17.8, triage is to occur daily. That wasn't happening with Mr. Jernigen. The note that Dr. Roemer takes from his chart, puts into the audit report says, Charles Jernigen inmate request, "Need to speak about problems." That's what he put in on the kiosk request.

Two days later he hangs himself alone in his cell. He told them, I need to speak to somebody, I'm having problems, and no one went and saw him and he killed himself. That is a pattern of failure to provide medical care in response to serious and obvious medical needs of an inmate.

Next page. Frankie Thomas. Date of the death was January 2nd, 2010. More than three years before Gwendolyn Young dies, there is a CH see 2009 alcohol intoxication protocol, L04. The patient appeared to meet criteria. Implementation of the protocol would very likely have prevented inmate's death.

If you'll just follow the policies that you have -- there was a great jury question about it, and it was, well, is NCCHC really just looking to see if the policies are in place or are they actually looking to see if they're being followed?

Well, this goes directly to that point, okay? I don't know who wrote the question but it goes directly to that point. Here we have Dr. Roemer saying, yeah, CHC has a policy, right, they're just not following them. The fact that they have a policy is evidence of their knowledge. They know or should know what to do. They just disregard it.

Same thing, slide 27. Damien Tucker. We talked about this, 42-minute delay in calling EMSA.

Slide 28. Clinton Labor, same thing. Two issues appear to be significant. First, there's a six-day interval between inmate request and mental health visit. Six days after he has expressed suicidal ideation no one saw him. That's deliberate indifference to a serious medical need. That is a pattern of failure to provide medical care in response to serious medical needs.

Slide 29. Linda Henshaw. We talked about Linda with her blood pressure, you know, 94/60. She had indications to send her out for emergent medical care. No one does it, she dies in the jail, cardiac arrest.

Slide 30. Patrick Gibson. This is an example of them not providing care as it pertains to the delivery of medications in the clinical setting. We've got Mr. Gibson here. The main concern in this inmate's care relates to a lack of follow-up in his metoprolol medication. If inmate had been on his medicine, his chances of having a fatal cardiac event

would have been significantly decreased.

We talked about Gwendolyn Young continuing to receive high blood pressure medication, despite her blood pressure being 80, up until the day of her death. No physician oversight. No one stepping in to intervene. No gatekeeping function at all in this very broken system.

Ms. Selgado. Slide 31. I asked Dr. Allen, "Okay. Similarly with Ms. Selgado, did you find that as it pertained to the medical director, Dr. Washburn, at the time, did he ever see the patient based on what information was being reported to him?"

"No. We -- or if memory serves, he might have -- there was no note in the medical record saying he saw the patient.

"QUESTION: Did you find in your review of Ms. Selgado's case that there were emergent medical criteria for immediate transport to a hospital but it was not followed by Dr. Washburn?"

"Yes. That being the chest pain with cardiac history."

Let's look at slide 33. Again, Dr. Allen's testimony also pertaining to this issue falls within this line of liability of the pattern of failure to provide medical care in response to serious and obvious medical needs of the inmate. His death was March 8th of 2012, about eleven months before Ms. Young died in the facility.

Again, the most significant crosscutting feature in

those medical cases was the fact that all three cases the patient spent multiple criteria for immediate referral and transfer to an emergency room but it did not happen.

Slide 35. I believe this is the last moving force policy, practice, and custom that we've identified in Ms. Young's case, but continuing to adhere to a deficient system of care for inmates with serious needs.

Slide 36. I asked Dr. Allen, "Don't you think that's concerning if you've got a nurse down there who is repeatedly failing to follow policies, procedures, and protocols?"

His answer, "It would be, yes.

"QUESTION: Don't you think it affects inmates' health and safety?

"ANSWER: It could be an issue, yes."

"Well, if they're not following the chest pain protocol, if they're not following the abdominal pain protocol, if they're not following the infirmary care admission protocol, you would agree with me, would you not, that can cause serious life-threatening risk to an inmate patient?"

Yes, it could." That was his answer.

That goes to this prong of adherence to a deficient system of care for inmates with serious medical needs.

Slide 38, Charlie.

Nurse Harrington testified when I asked her, "Nurse Harrington, during your time at the Tulsa County Jail, did you

experience inadequacies in the delivery of health care to inmates?

"ANSWER: Almost on a daily basis."

Because this wasn't just one-offs, right? Every death that was reviewed from 2010 forward that we've talked about in this case was determined to be preventible, every one of them. She was documenting it in realtime, contemporaneous notes. It was happening on an almost daily basis. She was the director of nursing. She was clearly trying to make things stop but the corporation didn't want to. They didn't want her there. They fired her three days before they promised Brian Edwards, hey, we're going to fix it, we promise. But that's just coincidental? I mean, that's circumstantial evidence, okay, of what their intent and what their disregard is.

Slide 40. Because there's an abundance of evidence, I'm just trying to hit the high points during the closing. But CHC's adherence to a deficient system of care for inmates with serious medical needs. These are the other relevant exhibits that I've not had time to talk about. If you want to go back and review them, here are the specific exhibit numbers and page numbers that will lead you to understand that this is evidence that establishes adherence to a deficient system.

The ICE audit, PX 61, letter from Paul Branstetter to Brian Edwards; the Roemer report, PX 1; Roemer's continued audit, Plaintiff's Exhibit 46; the NCCHC findings, PX 36.

Those are additional materials that support from an evidentiary standpoint the last prong that we're talking about, the adherence to a deficient system.

Lastly, I want to talk about the last prong and this is the sixth bullet point.

Slide 41, Charlie, please.

A pattern of failures to produce inmates with sufficient access to a physician.

Next slide. "Doctor, can you tell the jury would it have fallen below the standard of care in a correctional setting for a CHC nurse, medication aid to continue to give high blood pressure medication to a patient who had presented with a systolic of 80?"

"Yes.

"QUESTION: And did you find that it was continuing to happen when you reviewed the medical chart?

"ANSWER: Yes."

I want to look -- I've gone over my time a little bit but I want to look at Exhibit 21, Charlie.

From what I've gathered with the defense -- with their case, right, because they only called the medical examiner, who no one disagreed with his findings at all but that's who they put on, okay, and Mr. Winter towards the end of that examination looked at the medical examiner and said, Well, did her blood pressure cause her to die? Did the fact that she

continued to receive medication cause her to die? Did her nausea, vomiting cause her to die? Did her shortness of breath cause her to die? No. And no one said that it did. She died from blunt-force trauma to the head.

He said, hey, that could be a million different things, right? That's like their defense: These could have been a million different things. That's why you send them to the hospital. Because it could be a person having a heart attack. It could be a person having a stroke. It could be a person with a subdural hematoma. That's the whole point. There is a million different things that it could be, but you have to send somebody to the hospital to find out what it is. Very basic, right?

So to see them try to defend the case in a way that has absolutely nothing to do with the liability, it has absolutely nothing to do with it, it's just a way to try to confuse you about what's important. And that's not what's important. Everybody knows she died from blunt-force trauma, but everyone also agrees that it was likely within 72 hours of her death. If you go back 72 hours of her death, do you know where that takes you? February 4th of 2013 when her blood pressure's 80. That's where it takes you. That's 72 hours before her death. Look at the medical charts.

But this whole defense of, that could be a thousand different things, a million different things, we know. But we

know there's nine of the things that you got to send them to the hospital for, right? She meets three of them and you never send her out. Just like Elliott Williams, just like Linda Henshaw, just like Damien Tucker, just like Frankie Thomas, just like Clinton Labor, just like Charles Jernigen, all of them, they never got the chance because they just wouldn't send them out.

And we're going to talk about it in the second part of my closing about why that was, okay? But I'm going to sit down for now.

THE COURT: All right. Thank you, Mr. Smolen. It's -- my computer's showing 11:28 and it's my understanding at 11:30 there should be food for you, right? And I don't think you're going to be able to get everything done before a reasonable time for a lunch break.

MR. CHAPMAN: Oh, I will get it before 12:20, 12:15.

THE COURT: Do you think you'd be done at 12:15?

MR. CHAPMAN: Throw a lasso around my neck and pull me off if I'm not.

THE COURT: Okay. What do you want to do? Dealer's choice. Okay. Go.

MR. CHAPMAN: Thank you, Your Honor.

THE COURT: Okay. Thank you.

MR. CHAPMAN: I guess I made a commitment I have to go fast, huh? I don't want a lasso around my neck.

Again, like Mr. Smolen said, thank you so much for being here. I think the judge said it in the beginning: Our system wouldn't be the greatest system in the world if we didn't have juries. We don't settle our disputes out in the street with guns, with fists, with whatever. We settle them in here in a civilized world. You have plaintiff, who puts on a case, defense, who defends it, and the judge who calls the balls and strikes and makes sure we got done on time and makes sure the right evidence and all of that stuff gets in. So we're really appreciative of that.

And, of course, the unsung heros, the court reporter, the court's clerk. We remember this man. They take it all down they got to work fast and do that. So we appreciate all of that, and we appreciate your patience. When you're not here and you're sitting back there, not able to talk to the case, talking about whatever you want to talk about while we're out here working, I can just assure you as one of the attorneys here, that the honorable judge keeps us working. He's on time. And when you go out we're in session every day. Most days we stayed here close to 6:00 or even longer. So I appreciate that.

Am I up?

This case is not about the deliberate indifference of people or the negligence that people might have about taking care of a patient regardless of the patients that were

identified. This case is about "CCH." It's about a corporation. Did a corporation have policies that forced these other issues to happen? It's not about the doctors. It's about three people and I'll mention it to you in a moment. But it's about the corporation. And it's about plaintiff trying to villainize a corporation.

I stand here today with the pleasure of representing, along with my co-counsel here, Sean and Anthony, and the corporate representative, Jamie, representing a corporation. They are not the bad guys in America. Corporations provide the health care. Every hospital is a corporation. Of course, they are. We're not the villains. Corporations are made up of people that do things and we're here to talk about that.

If you look, there's four things we have to talk about. You're going to receive jury instructions that address these four topics in general. Jury instructions are a little bit longer than that, they address some other things.

The first one is that I want to address is the cause of death. And then we're going to talk about the moving force, something that plaintiff counsel, if you read into it, may have been talking about that, but it's more specific that we have to talk about. And then the actions of Ms. White, Ms. Metcalf, and Dr. Adusei. Regardless of Dr. Washburn, regardless of the nurse practitioner, regardless of anybody that was involved in the care of Mr. Williams, the care of any of the other people

he mentioned, these are the only three individuals that are involved in this case and you're going to read them in the jury instructions. It's not all these other people that are mentioned.

And then, of course, we had the policies, procedures, and practices, which is really the case that's at issue here. The case at issue is, did the corporation have policies, practice, procedures, customs that they knew about and they knew that these things were causing, not just deaths, that they were causing serious injuries, that they were making the inmates -- that their health was always in peril, all of these kinds of things.

Focusing on -- and I'll talk about this in a moment -- but focusing on some deaths that occurred in a two-and-a-half-year period when, if you calculate that, about 85,000 inmates -- no -- about 82,000 inmates had gone through that system. That's not a high number. It's a terrible number because people shouldn't have died. People die in hospitals. People die.

Every one of these cases talked about, except Ms. Young, and we heard some longer evidence of Mr. Williams, there's whole other issues of the health care that was going in that's not talked about because we're not here to talk about those people, whether people were negligent, whether people were deliberate indifference. You didn't hear all that

evidence so it's hard to make a judgment call: Was this poor care for this person or that person? You heard a few things highlighted. But to highlight a few things aren't the medical record. They aren't the details of what did the physicians know or not know. What did the nurses know and not know that they made decisions on? And that's something that we're going to go in and we're going to highlight a little bit.

So let's talk about the cause of death. And I thank brother counsel for bringing a couple things up that I don't have to address. His math may have been a little off. The time period is 10:00 a.m. on February 8th to 10:00 a.m. on February 5th. Count back 72 hours, that's 72 hours.

There was discussions with the medical examiner and he was firm. Why was he firm? Because as a scientist, he could look at the blood, whether the blood was properly coagulating fibrous tissue coming together in the cells, scientific evidence to slow that this could be no more. It could have been one day. It could have been 24 hours. But it's no more than that issue.

Why? Because of these things: No signs of healing, it's acute. Why are these important? Because plaintiff talks about blood pressures that occurred on the 4th, blood pressures that -- that -- or I'm sorry -- on the 6th and on the 7th and things that might have occurred back in January, showed you all the medical records. Those things aren't relevant in this

case. They're not relevant in this case. It's the last three days that are relevant.

And we're also talking about issues of knowledge, and you're going to hear those issues and I'm going to talk to them a little bit more. But did the individuals have knowledge? You're going to read the jury instructions that they had to have knowledge. They had to have knowledge of this serious deed. They had to have knowledge of subdural hematoma. And they couldn't have. There's no visible external signs. There's none.

The expert, Dr. John, talked about in a African-American or a dark-skinned person, it's hard to see a bruise. Plus, when you add hair on top of that, you can't see that. Nobody saw that. No clinician had the knowledge of a subdural hematoma. If they don't have the knowledge of it, you can't hold them responsible for it.

Now, Mr. Smolen made my point, and that is that the symptoms that she had -- and they're in the record -- could cover, what did we say, a million, a hundred-thousand, a thousand, all kinds of things. You don't send somebody to the emergency room because they're vomiting. The emergency room would be filled with people that are vomiting. You send people there if there's a reasonable belief, if we're looking at the general issue, a medical necessity that there's a reason for them to go.

In this case, if they didn't go because one or more health-care providers made a mistake, were medically negligent, that's not an issue and that's not deliberate indifference and that's not a reason to find CHC responsible. It's just not. The case is trying to be made about people that aren't part of this case.

The case here, the sole issue for you to decide, are the policies that "CCH" implemented the driving force behind this death. That's the issue. It's not that people at the death committed medical malpractice, deliberately indifferent. Should Dr. Adusei have done something different? Should Ms. White have done something different? That's not the issue. The issues were they medically -- sorry -- the issue is whether they were deliberately indifferent to something. The other nurses and doctors and things involved they're not at issue here. It's only the three that are at issue in this particular case.

And then we look at the subdural hematoma. And, again, I won't stay on top of this point because plaintiff's counsel made that point for me. None of these issues, including the issues of breathing difficulty or the argument that she may have complained that she had chest pain, none of those issues caused the subdural hematoma and that's why she died. And when you look at and you go back to the autopsy, there were no cardiac issues. There was no ulcer or bowel obstruction or

anything that would have caused anything. We know in hindsight that any of those were medical issues that should have been brought to an emergency room or that didn't. The theory is, well, if you would have sent her, they might have seen this. But think about it. If you go to the emergency room because you're vomiting, they're not going to do a CT and they're not going to do it until there's some belief that that's a problem. They're going to work it out.

So if you send her to the emergency room at 6:30 in the morning of the 8th to say that before she died at 10:30 they would have discovered, oh, it's a head issue and we're going to do a CT, then we're going to get a surgeon in, and then we're going to do a procedure to, you know, relieve pressure and things, that's just not going to happen. There was testimony to that effect.

Moving force. A huge issue in this case, a huge issue in this case, and something that we have to talk about because it is the achilles heel of the plaintiff's case. That's probably why they didn't address it in the way that they should have addressed it.

Remember the moving force. The judge is really good in coming up with analogies when you're not in the room to explain the differences to plaintiff and I. I might not be that good at it but a moving force is like you have a vehicle. You have a bad door, you have all these things. Mr. Smolen used an

example like that. The moving force is the engine. You have to have the engine. In this case, the moving force is the engine. Without the engine, you don't have a car. If I remember his analogy correctly, it's the engine we're talking about, the moving force.

So what is the moving force? Well, you're going to read this in the jury instructions, and you have to have these four things. They're not going to be labeled one, two, three, four, they're actually said in a sentence. But you have to have a custom, policy, or practice -- the big word is "that" -- sets in motion a series of events that CHC knew, or reasonably should have known, would directly cause the violation, which in this case was a subdural hematoma that led to death.

Now, their other argument, because you're going to read the jury instructions, there's method one and method two and we're going to talk about that. Method one has to do with the individuals in this case. Method two has to do with policies and procedures. But you're going to see this jury instruction. This is extremely important: Custom, policy, and practice.

What we've heard throughout this trial and throughout Mr. Smolen's, you know, limited opening and then -- when I mean limited, he has an hour and a half, he reserved time to rebut what I have to say and say whatever -- that CHC had these policies, CHC had this, CHC did this, CHC sent Dr. Herr in and they looked and they said, hey, we're going to try to do this

better, we're going to try to do that better. We had good policies. We had good policies and procedures.

If one or two or three -- in this case, three individuals -- didn't follow those policies on occasion, that is not liability of CHC. They have to have knowledge. Look at this: Set in motion a series of events. Did CHC set in motion a series of events? We're going to talk about the NCCHC. We're going to talk about the audits. We're going to talk about in a moment that they have never lost accreditation.

I don't care what Dr. Roemer says. He is not a NCCHC auditor. We're going to talk about that. I'm going to give you a quote. Even Mr. Turley when he was here, critical, what did he say? We thought he was more after money to keep the contract than he was truly analyzing what was going on. Think of that. That's the person that actually hired him that said that. And he was an emergency room doctor, had nothing to with jails, had nothing to do with NCCHC.

And then you get to that CHC knew, or reasonably should have known, what directly caused the violation. Now, Mr. Smolen makes the point of Ms. Metcalf. And, yeah, she had problems. She was disciplined. Ms. Harrington had problems with her. Ms. Rogers had problems with her. She was written up. She was given warnings, although some of those are way separated in time. There were corrective action plans to try her to get in place. I think the theory is the very first time

she should have been fired. But we know the company has an HR, human resources, where these things go to. That doesn't always happen. There has to be progressive and you put somebody on a corrective action plan and you do some things. And, yes, ultimately they terminated her because these things continued to happen what they did.

But you're going to learn she is not one that's involved in this case in a big way. She was there once on the 8th when she was brought down to the infirmary. She was there in the emergency call at the end but. She didn't do any care. She didn't deliver any care. There were other nurses and doctors that did that. And then she was once involved on the 6th where she came in, she was already on the unit, she saw Ms. Young, didn't write a note, didn't write anything. But if you look at those logs, which I don't remember the number of, you'll see hours before, hours after there's no complaint in the logs by the deputies or the detention officers about anything going on.

So while she was potentially an employee that needed to be terminated, a bad employee that couldn't be rehabilitated, etcetera, a red herring to this case. She didn't cause the death. She had nothing to do with the death of Ms. Young.

And then you look at: Would directly cause. I highlighted that. It's not in the jury instructions. But directly cause means directly. Now, you're going to read it

can be a motivating factor. It can be directly caused. In other words, multiple things could cause something but this violation has to directly cause that injury, directly cause. Not in a roundabout way but directly cause. And we're going to talk about some of those policies and procedures.

Moving force. These are all the elements that plaintiff showed you that they believe are the policy and procedure violations. They call them the systemic failures. But let's talk about them. Systemic failure of medical policies and procedures in general. We'll talk about the NCCHC. That's the gold standard. They met those.

A pattern of failures to provide medical care in response to serious and obvious medical needs. Well, they talked about four people in specific: Williams, Delgado, Brown and Ms. Young. In passing, he raised other people that had passed away. No other medical person talked of those. You had Mr. McKelvey talk about some of those. He's not a medical doctor. He's an investigator. The fact that he can say that something caused somebody's death is completely irrelevant. He has no knowledge, no expertise to say any of that kind of thing. And you don't have the medical records of any of those persons.

What you have is almost -- well, approximately 80,000 inmates that go through. You can't base a pattern off of three, four, five people. And remember, we're just not talking

about people with deaths. To say there's a pattern of failure, you'd have to be talking about a failure in sick call, a failure in intake, a failure in chronic care, a failure in all these things and it hasn't been proven at all. Because remember, we're talking about the corporation.

Don't get your sympathies, don't get your -- say, oh, this person was treated poorly to say the corporation's responsible. It's not responsible. If I'm in a vehicle that's owned by a corporation and under these kinds of circumstances I get in an accident, it's not the corporation's fault. It's my fault. It's my fault. And that's the thing here, the corporation.

They're made out and they will be made out in a moment when plaintiff comes back up here and talks about damages and talks about how the corporation is a villain and you have to punish the corporation, and they knew this and they knew that, and therefore, give 10 million, 20 million. I think he said he's going to ask for $41 million because the corporation is so evil. I'm here to plead with you and tell you the corporation isn't evil. The corporation didn't cause this.

They had policies and procedures in place. Failure to provide adequate training. That's not what NCCHC said. Now, that's what Dr. Roemer said. I don't know what Dr. Roemer knows about the training that's necessary to be in a prison or to work in a jail. I don't know. I don't think he has the

authority to say that.

Continuing to adhere to a deficient system of care for inmates. What deficient system? Yes, there were some things that happened to some people. I didn't like the video of "Ms. Williams" either and I'm sure you didn't. I didn't like it. I don't think "Ms. Williams" should have died. That's not at issue here.

What's at issue here is Ms. Young. The issue here is Ms. Young. And the issue is whether or not the corporation knew the policies, customs, and practice that were the motivating factor -- a motivating factor -- that directly caused a subdural hematoma that caused her death. I know that was made light of -- not so much made light of -- but it was in passing when plaintiff came up here as if he gave it three seconds, just completely dismissed that, that doesn't have anything to do with this case. But that's the crux of this case. If you believed that individuals were responsible, you could have been after those individuals. They're not here on trial. The corporation is on trial.

We went over this, the idea that aspirin, that blood pressure, that back pain, that any of these caused the death is wrong. Blunt-force trauma was the moving force. And one of the things the judge allowed, which I thought was actually very good because it allowed us to see some of the things that the jury wanted to hear, is you were allowed to ask questions which

I thought was really, really good. You asked a lot of these questions regarding blunt-force trauma. You asked questions of could the blood pressure have caused that? Could it have been a factor? Could the aspirin have been a factor of it? Could the trauma have occurred if she rolled off her bed? And Dr. John said no, unless you rolled off like a top bunk and you hit your head really hard. There weren't bunk beds in there. And I don't know if any of you have had back pain. I've had it at times. Sometimes the only time I feel good is if I'm laying on my back on the ground.

I don't know why she was there. I know she was complaining of back pain at that time. And, again, the system was not failing. NCCHC national standards were being met. Yes, they were on probation. Is that a bad thing to be on probation? Well, it's not a good thing to be on probation. But it's a good thing to get your changes in place to create a corrective action plan.

I will suggest to you -- I don't know NCCHC personally and I can't tell you what they do or how they do it other than they do these audits -- I suspect because they're a national accredited association and they accredit people, they have a reputation to maintain. They don't take it easily when somebody has probation and then comes off probation. They make sure that they put in place a corrective action plan. They make sure that that plan is approved. They make sure that it's

properly implemented. And as you heard, they come back and do a mini-reaudit at some time in the future to make sure it was.

The fact that they came off of probation -- and, again, don't lose sight of this. It's late 2010, early 2011. It's almost two years and three months before any of this happened, before any of this happened, and they implemented a quality control -- continuous quality improvement program.

Now, you heard of ICE coming out. You heard of meetings with the sheriff. You've heard of meetings with risk management. You've heard of staff meetings going over problems every two weeks. You've heard of online continuous training. All of these things were implemented for continuous quality improvement. This shows that a corporation cares. They don't want bad delivery.

Do you know how -- you're going hear about how CHC is a for-profit corporation. I don't deny that. I don't think that's a bad thing. Do they want to create a system that continually causes problems? It's not in their best interest to do that. So they put a quality improvement -- continuous quality improvement in. They have corrective action plans. They discipline people. They do the things that they need to do.

And I will say this: If they're not doing these things -- we all heard from Ms. Harrington. I don't believe there was a nurse there that she thought was good as her.

There are a lot of difficulties I have with her testimony and it goes back to why she was terminated. I have problems with why she was initially disciplined. But there are some things that I saw or felt a little ironic. Remember, one of the employers after she left CHC, she was there for -- what did she say? -- six weeks and she couldn't tolerate their policies and procedures and the way they operated so she left.

But here, she'll stay four years, three years in a system that she says is completely failed, nobody does anything right here, et cetera, et cetera. Well, then why does she say? It doesn't make any sense if she has that internal insight that says, hey, that is a terrible system, I have to leave. Her argument is, well, I was trying to change it from the inside. That's a good thing.

But remember some of the things she also said. In the middle of the night -- well, she actually didn't say in the middle of night -- there's boxes and boxes and boxes of records that people are feverishly preparing in a backroom and shipping them out. One, it never happened, and you heard it being denied; but two, it wouldn't matter. NCCHC comes in and randomly picks off a roster that has nothing do with the records you have. And then they say, I want these records. They didn't get the records they wanted, it would be in their reporter. It would be in their report and they would say, I'm missing this record and this record. Why? That would go to

their recordkeeping. It would go to whether they had the records in place.

So that's just a red herring. It didn't happen and it wouldn't have anything to do with anything. It would not have stopped this particular all. And, again, the alleged practices did not directly cause the injuries.

Now let's talk about the individuals. Because, like I said -- I have to keep my promise to the judge -- there's two ways, there's method one, there's method two. Method one has to do with individuals. You have to find, if you go under method one, that Ms. White, Ms. Metcalf, Dr. Adusei had knowledge -- not all together; it could be, you know, one individually -- had knowledge of a serious medical need, a subdural hematoma.

And remember, Dr. Adusei didn't treat Ms. Young the day before, the week before, the month before, two months before. He didn't know of a subdural hematoma. Ms. White didn't know of a subdural hematoma, but we're going to talk about it, but she saw her on the 7th and on the 8th. They have to know when they disregard it. In other words, I have to know you have this. I have to knowingly disregard this that causes harm. Think of that. That's not negligence. That's not a mistake. That's not doing something wrong. That's an intentional thing that's going to happen.

And then we look at what did deliberate indifference is

not. It's not medical malpractice. It's not a mistake. It's not following an NCCHC standard. It's not knowing of a serious medical need. It's knowing of a serious medical need and not doing something. In other words, if I don't know, I can't be deliberately different. It is against the interpretation of the law that the judge's going to give you. That's what sets it apart from medical malpractice. And actions in this case that were weeks, months, years before Ms. Young's death are completely irrelevant to this discussion. It's completely irrelevant to this discussion.

Let's talk about Dr. Adusei. He did not treat. He wasn't called. The nurse practitioner was, not him. He did not know the subdural hematoma. He appeared on the scene. And he said when he got there, he believed Ms. Young was already deceased, but he explained to you that they continued doing cardiac -- or CPR until EMS gets there. EMS does things. And then when it's completely futile, then the person is determined to be dead. But you keep trying because something could happen. The person could be revived, et cetera.

There were comments that there wasn't epinephrin, there wasn't some other medication there to deliver. It isn't there. It's not on that crash cart. It's not required in a jail. EMS would have brought it and they would have given it, if it was necessary to be given.

And even if it wasn't there and it should have been

there, it didn't have an impact on her death. It didn't have -- you know why? She didn't die of cardiac arrest. She died of a subdural hematoma, not of a cardiac arrest.

And then let's talk about Ms. White for a second. She did see her two times -- Ms. Young -- two times in this scenario that we're talking about. The first was on 2/7/2013 for vomiting. The complaint, not the observation from the detention officer, not the observation from Ms. White, but the complaint was that she was vomiting up blood for three days. Now, we know in hindsight, she could not have been vomiting up blood in three days. There was nothing wrong with her system that would cause that. There was not a deterioration of her organs.

Mr. Smolen told you that she was slowly deteriorating because they weren't doing anything. No, she had a subdural hematoma. All of her organs were okay. Her heart was okay. There were are no ulcers. There was nothing wrong with her. There was no bowel obstruction. There was none of that. It is impossible in this case for her to be throwing up blood, and we know this afterwards. It doesn't mean she didn't vomit. In fact, there's evidence she says that she vomited in the note. But there's no evidence of blood.

So what did she do? She checked the detention officer's records. She saw that she had been eating her meals. Well, that's a good thing. She advised her to drink -- you

know, continue to drink water and that she would be, you know, re-assessed. Now, I guess the argument is she should have been rushed to the emergency room because she was vomiting.

I think it doesn't take a reasonable person -- and the judge is going to say that you should use your reason. You don't have to give up your reason, give up your mind, give up your experiences, give up your intellect when you go back to the jury room and make decisions.

So we know, because we know of the autopsy, what it says and what it doesn't say. There was nothing else wrong with her.

And all this about Dr. Allen. Do you realize Dr. Allen investigated this case because he was convinced that she had a cardiac arrest? Except she didn't have a cardiac arrest. She died of a subdural hematoma and the doctor explained that to you. And Ms. White had no knowledge of that.

Now, on the 8th -- this is important because I thought I heard statements, I'm not sure -- that Dr. Adusei was involved in this. He wasn't. This was the nurse practitioner.

Now, what should a nurse do when a nurse does an assessment? A nurse should work it up and call the health-care provider. A nurse practitioner in the state of Oklahoma has the same rights to treat, to prescribe as a physician does under this context. They called her. She made the call. This decision was not the decision, whether it's right or wrong, of

Nurse White. It was the decision of the nurse practitioner who, by the way, is not on trial. Not on trial. CHC is on trial. CHC is on trial.

And then you go to Ms. Metcalf. We talked about her. She has problems. But she wasn't there. She saw once on 2/7 at 1608, which is 4:08 in the evening. That wasn't an issue. It's not even been brought up. There's nothing wrong with it. Yeah, there was a point in one of the videos she was brought up on that video but she didn't have any involvement in this.

So what do you have to find with respect to these individuals? Go back. These individuals first have to be deliberately indifferent and the deliberate indifference there has to be related to a custom, policy, or practice of CHC. Nothing CHC did was related to or caused these people to do these things.

So now we'll go on to Ms. Harrington. This is the only thing I'm going to say about Ms. Harrington. I don't know of any nurse refusing when it was determined they really need medical care. That is the -- that is the opposite of deliberate indifference. That statement says, I don't know of any nurse that was ever deliberately indifferent. Yeah, they didn't follow some policies and procedures. Yeah, they didn't do this. But I've never seen a nurse not do the care that's needed when somebody needed it. Now, the good thing about that, from somebody who's never seen somebody do a right thing

in the jail, at least she admitted this.

Now, policies and procedures. NCCHC is the gold standard. How do we know it's the gold standard? The sheriff, through Mr. Turley, coveted it, the triple crown. NCCHC was part of the triple crown. It wasn't what Dr. Turley says. It wasn't what ICE says. It wasn't what Dr. Herr says. It's the NCCHC that means something. So if it means something, it ought to be applied in this case.

And here's the thing. It's an objective assessment from somebody that doesn't have a horse in the race. They don't care whether you're accredited or not. They're here to be scrutinized -- I mean, to scrutinize your process. And how do I know that they're here to be scrutinized? I'm going to go into a slide in a moment on how they come in and do an audit. But before I get to the slide, I think this is important.

They were accredited in 2007, CHC was. I don't know if the jail was accredited before that but it might have been. But CHC came in, CHC applied for accreditation, or continued their accreditation, I'm not quite sure, but they were accredited in 2007.

2010 -- there's a re-accreditation every three, four years, I think. 2010 they were found to be on probation. They submitted their plan, it was accepted, it was implemented, it was re-audited, and full accreditation was granted. Now, if NCCHC is the gold standard and the coveted triple crown, this

is proof that the corporation's policies and procedures qualified, supported the standards.

Now, you're going to read in the jury instruction that an individual not following one of those standards is not deliberate indifference of the corporation, that under this theory you should find them liable. This is the second theory -- or the second -- I can't remember the court's word. But there's two options, theories --

THE COURT: Way.

MR. CHAPMAN: Way. This is the second way, dealing with these policies and procedures.

Never lost accreditation. You've heard a lot that they were put on probation. You've heard a lot about Mr. Roemer -- Dr. Roemer. You've heard about ICE coming in. And remember the thing about ICE -- I'm not going to spend much time on ICE because what did they look at? They looked at the same records -- or at least some of the same records that NCCHC looked at in 2010. Well, if you look at the same records and you find some of the same problems, is that a surprise? No. ICE didn't come in and do an audit.

If you look at that exhibit, you will see 80 percent, 90 percent of that exhibit is all things that the jail didn't do. They didn't have a barbershop. That's one that sticks out in my mind. They didn't have other kinds of things that were there and a list that had nothing to do with medical except the

two or three things that were listed.

Now, let's look at the audit. Two full days of audit, two, with six-plus auditors going through the entire facility. That's not Dr. Roemer. That's not ICE. That's not anybody. It's not Dr. Herr. It's nobody. It's the NCCHC that did this. And if it's the gold standard, if it is something to be coveted, if it means anything, you've got to go with the experts. It's not an emergency room doctor that comes in and is evaluating intake in a jail, probably comparing it to intake in an emergency room. They're different.

And they reviewed 30 to 40-plus records in all of the different service areas. That's now .00029 percent of the records that Mr. Roemer looked at because he only looked at records from one day, 90 records, out of 80,000. And those were picked in one day. They weren't randomly picked. They didn't use a random number generator that you would use to truly do an audit like that.

And NCCHC interviewed the nurses. I don't know if Ms. Harrington said she was interviewed, but if she was so concerned, she probably was. She was in a position to be. We don't know for sure. They interviewed the providers, the sheriff, which probably would have been the captain in charge and things like that. They interviewed the inmates. Not all of them. They just picked -- randomly picked inmates or they might interview inmates that they pull medical records from and

then talk to them. But they interview all of these people. You don't see that in Dr. Roemer's report. You don't see that in ICE's report. And then they go on and they do direct visual inspection of intake, sick call, infirmary, nursing assessments, and other things, and then they write an unbiased report.

That's what we're here for. Did CHC not have policies and procedures -- or more importantly, did they have policies and procedures that they know were systemically -- not one time, not two times, not ten times, not fifteen times -- systematically for all the patients every day throughout the hospital -- or throughout the jail not followed. You can't do that on three or four people or five people.

And then they wrote a written, unbiased report. There are some things in there that aren't pleasing, there are. There are some criticisms. But there's a lot of good things in there too. And so if you pulled up that -- I can't remember the exhibit number -- you would see -- I just show this for an example -- those are the deficiencies in the essential standards. We're going to have them in a better -- here's the first few of them.

Administrative meetings had nothing to do with Ms. Young's death. Emergency response, nothing to do. Infection control, initial assessment, oral care, nothing to do. Now, did she have an initial assessment and oral care?

Sure. But they had nothing to do with her death.

Continuous quality improvement, one can argue, plaintiff will argue, did because why? It failed. It didn't find these problems. But it didn't fail. Even Ms. Harrington said she sat in on meetings. They had this system they went through and they tried to find problems.

Now, granted, they found this in 2010 and it was implemented after 2010. This death occurred in February of 2013. Continuous quality improvement was implemented. That is the way that a corporation can ensure that their policies and procedures are followed. It's the only way that they can. And they did it. And they did it.

Now, Dr. Roemer says, well, that's a completely inadequate system, it's antiquated, it's inadequate. I don't know what he's comparing it to, but he doesn't know anything about jails, we know that. He may be comparing it to a hospital which is a completely different system. They operate under different rules. They're not accredited by NCCHC. They're accredited by different organizations.

And then we have these two. Nonemergency health care requests arguably applies to Ms. Young, and we're going to talk about that. Continuity of care doesn't. She had been in the jail for a decent amount of time. Chronic diseases in patients with special needs isn't an issue here. Suicide prevention is not an issue here. And infirmary care could be an issue,

arguably is an issue.

So J-A-06, that's the one that they found quality improvement that that was a problem, continuous quality improvement. They implemented a more comprehensive program, biweekly meetings, online continuing education, CQI meetings. Those meetings with the sheriff, those meetings with these others, those weren't meetings for the sheriff to come in and, you know, chew them out for not doing this or not doing that. They were quality improvement meetings.

If you can't be frank and transparent and open in a meeting to talk about your problems, why have the meeting? The meeting's there to identify the problems, and they did identify some problems that they continued to work on.

I don't believe -- I don't think anybody in this courtroom believes that you could be one and done. You can just say, here are the policy and procedures, go follow them, I'm going to assume you're doing a great job. It's not how it works. It's certainly not how medicine works because things change. You have to continuously look at it, continuously try to find things.

They did have it. Ms. Harrington even said -- we're not going to this pull this up because I want to keep my promise to you -- but she said, we had meetings, I attended meetings. Remember, she said they talked about statistics, statistics about chronic care, statistics about sick care,

statistics about all these things so we can improve the system.

J-A-06. CHC made changes. They made changes. Dr. Herr was there and they made changes. That was a dig deal that Dr. Herr said we're going to terminate Dr. Adusei and they didn't terminate him for some time after that. Dr. Adusei wasn't involved in the death of Ms. Young which is why we're here. You didn't hear testimony about Dr. Adusei running around and having problems. Now, you did hear somebody say that he had alcohol on his breath and you heard Ms. Rogers say she talked to him, there was no evidence, there was nothing they could do. That's one person complaining.

How do you know that one person complained? Ms. Harrington said somebody told somebody who told me. Ms. Rogers said she was told by Ms. Harrington and she went and inspected it.

You also heard that he did some things with respect -- they wanted to work on him doing more consistent rounds in the infirmary. They wanted him to have dates that he would specifically do things. You heard in Ms. Harrington's stuff that he said, I'm not going to see a patient until he's septic. He testified that stuff's ridiculous. He didn't do those things. He didn't do those things.

And consider -- you will consider the character, the truthfulness, et cetera, of who you want to believe. Do you want to believe Dr. Adusei? Do you want to believe all these

things that Ms. Harrington had? That's up to you to do. But here's how you do quality improvement. You implement, you train, you review, you test, and you repeat. That's the very nature of us getting better and them getting better.

Nonemergency health care. Here's the argument that was made by NCCHC. However -- however -- interesting word -- it means everything is going good, however. There's a problem. The problem comes after the "however." Nursing staff are not always told when the kiosk goes down. Well, who's responsible for the kiosk? It's the jail. And that they need to pick up sick call slips. If they're not told, they cannot be deliberately indifferent.

Remember, you have to have knowledge and disregard a serious need. That's on the jail and then that resulted in people not getting to sick call within a week. There was no argument that Ms. Young didn't get to sick call. There was no argument that she didn't get to see somebody in a timely manner. It's not the issue in this case.

And then infirmary care. I'm going to read this to you because it's important. Specific scope of medical, psychiatric, and nursing care provided in the infirmary setting is defined by the policies and procedures manual. They had a manual. Patients are always within hearing of a qualified healthcare professional. At the time of the survey, a new speaker system was implemented or being installed. Registered

nurses and LPNs 24-hour coverage in the infirmary. A supervising RN is on-site at least daily. And a manual of nursing care procedures is available.

So what did they do wrong? It's a paperwork issue. The physician didn't sign the admission or discharge infirmary care documents. That's the violation. Now, that's a big violation to NCCHC, and, granted, it should be. But that's not what caused any care or deficiency here.

ICE report, we've already talked about that. Mr. Roemer -- Dr. Roemer, we've talked about it, local emergency, never worked in a jail. Mr. Turley, the county auditor, only after money.

Let's talk about this for a second. Ten million, twenty million, thirty million, a hundred million, send a message, the company deserves it, punish the company, do this and do that. That's what you're going to hear. You're going to hear this. Give us money.

Now, I understand money is the only way we can redress things. We can't give people back. But here's the thing. The health-care providers are not on trial here. The corporation is on trial. And you're going to hear an argument that the corporation -- I think the figure that plaintiff wants to use is over nine years they were paid $4 million a year to provide health care. You will see in the contract that they had to employ, I think it's about, 15 or 16 people. So they'll argue

that that's profit. There's probably very little profit in that. But he's going to argue that they're this big corporation that made 37 million because that's going to be a big number to you. He's probably -- would be to me. He's not going to tell you it was over nine years. He's not going to tell you that they had all these people that they had to employ, but you'll have the contracts and you can look at that. You can look at that.

The other thing he's going to come up here and tell you is that everything I said was wrong. That's just the way the system works. But I want you when you go back to use the talents that you have individually. You come here with a different perspective in life. Talk about those perspectives. Talk about what you heard. Talk about what you -- what you want to apply, what you think are the problems identified here that you want to consider, that you want your fellow jurors to consider. I'm not afraid of you looking at everything in this case and I hope that you do. Of course you probably don't want to be here eight days, so look at what you think is relevant in this case and then make your decisions. Make them based on sound reason. Don't make them based on sympathy.

I ask you that you don't make them based on because you believe CHC is some evil thing lurking out there that's just trying to kill people. I assure you they're not. It's against their best interest to do that and they didn't do it in this

case. Yes, there were deaths. There are always deaths in jail. There are always. The amount of deaths that occur in jail is very similar probably to the amount of deaths that occur in a hospital, the amount of deaths that occur in any other -- there are people that come there that are sick. Inmates that come into a facility are not the most well people and there are 2000 of them at all times.

So on behalf of CHC, on behalf of my colleagues, Sean Anthony and Jamie, we thank you for listening. Our hearts go out to the family. Nobody should lose a mother, a sister, a brother, but it happens and it's not CHC. It may be the fault -- some of these may be the fault of an individual, but that's not the issue here, unless it is Ms. White, Ms. Metcalf, or Dr. Adusei, and they weren't involved. They did not cause this. And Ms. White, she called the nurse practitioner and that person is not on trial.

So on behalf of my client, on behalf of my colleagues, we thank you, we thank the judge, we thank everybody here involved. Now the hard work, after Mr. Smolen comes up, is for you. You have to sit in judgment. You have to go through a lot of stuff. You'll have the exhibits to go through what you want. I thank you.

THE COURT: Thank you, Mr. Chapman.

(Discussion held off the record)

THE COURT: We're at 12:20. So total what are we

looking at for rebuttal after we shave off that?

DEPUTY COURT CLERK: Thirty-one minutes and --

THE COURT: Thirty-two minutes. Want to go another 32 minutes or take a break, a short break? We're looking at a short break. Okay. We'll take a five-minute break. We'll come back, okay?

(Jury exits the courtroom)

THE COURT: The record will reflect the jury has left the courtroom to take a break and finish up with rebuttal.

(Short recess)

(Jury enters the courtroom)

THE COURT: You can have a seat.

All right. So Mr. Smolen's going to have his rebuttal, then we'll take our lunch break. When we come back, we'll go over jury instructions so you can leave the instructions on your chairs during the lunch break and we'll come back and we'll do that and you'll go deliberate. Before you deliberate, we'll have to swear in the CSO to watch over you, okay?

So whenever you're ready, Mr. Smolen.

MR. SMOLEN: Thank you, Your Honor. Defense counsel stood up here in his closing and he said, I'm sure Mr. Smolen is going to stand up here and tell you that everything I said is wrong. I'm not going to waste my time doing that, okay?

Let me tell I how easy it is. I counted he said "subdural hematoma" like 68 times. Look at the jury

instructions, the entire jury instructions. If you can find the words "subdural hematoma" anywhere in them, let me know because I can't find it. That's because it doesn't matter. He wants to make it matter. It doesn't matter. That's why it's not in the jury instructions. That's why he's wrong. They don't have to know that she has a subdural hematoma. You can't diagnose it without a CAT scan. You got to diagnose it in a hospital. He's literally telling you we're not responsible for any death under our care as long as he can't prove that they knew through a CAT scan that she had a subdural hematoma. That's absolutely false.

And it's purely stated to mislead you. It's highly offensive for me to observe it happening because I know what's going on. You know what's going on. But I'm a professional attorney and it's hard for me to watch it. I think it's totally disgusting. It's so wrong. Because that's not the issue. That's just a way to try to deprive the family of justice. But you guys are all smarter than that and you took notes the whole time.

Charlie, let's look at slide 1.

I want to talk to you about that while we're talking about the topic of things that are said during this case, okay? This is Mr. Chapman during Nurse Harrington's testimony.

"Now, you testified a lot in the Williams case and you went over four, four and a half hours of things that happened

in the Williams case and the sad death and all of those things."

Every death is sad. Every death is sad. Death is sad. But we're not talking about sad deaths. We're talking about people who have been tortured to death in our county jail. That's what we're talking about. People who could have been saved if they had just been sent out to a hospital. That's what we're talking about.

When you look at the contracts -- and I don't want to waste the time to pull it up -- but look at any of the contracts that are exhibits in this case. There is a paragraph in the contract and it says that if you have to send somebody -- CHC, if you have to send somebody to the hospital, you got to pay for their care. That's what it says.

So for him to stand up here and tell you, why would we have any incentive to do that, because it makes them a ton of money every time they don't send an inmate to a hospital because they have to pay for it. That's why these people with very clear serious medical conditions are not being sent to a hospital.

Look, I'm not up here saying we can't have this industry in the United States. But it is an industry, okay, and we can't allow it to exist in this dangerous condition. That's it. You can't allow it.

So look at the contract. If you want to know why

they're not sending people, it's -- they know all of these things, right? We sat here for days putting on just a mountain of evidence. But they're not going to send them because they have to pay for it. It's absolutely disgusting. They hold them there. They hold them there while they die so they just don't have to pay for the medical costs because it cuts into their profit. I'm not telling you it's evil. I think you know it's evil. Look at the evidence. It's absolutely disgusting.

In the United States, if we're going to house people for incarceration, for punishment, right, all those people have to rely on are prison officials to make sure that they get basic constitutional health care. If they don't, it results in lingering death and torture. That's what this case is about.

He sat here and told you, oh, all those deaths aren't relevant. Those are the patterns and practices that establish deliberate indifference. Those are the cases that establish their knowledge. It's absolutely disgusting.

Look, I -- Bryon is from Tulsa. I am from Tulsa. You guys are from northeastern Oklahoma. I very much appreciate this judge coming down from Illinois, okay? I very much understand that these lawyers are not from here and that they've left families to be here, okay? But this is our community. This is where we live. We have the right to say this is not acceptable here. That's our right to do that.

Mr. McKelvey -- Captain McKelvey testified -- and this

was really -- it was really overwhelming for me when it happened -- and he talked about the skull-cap guy was the first guy that he investigated that had had a subdural at the jail and they caught it and he was sent out.

Bob Byrd was my neighbor, okay? And I know how it affected his family. We had family that went to school together, okay?

MR. CHAPMAN: Your Honor, I'm going to object. His personal feelings about somebody that's not at issue here are not relevant.

THE COURT: Sustained. Mr. Smolen, if you need some time, you let me know, okay?

MR. SMOLEN: I'm good. I gotcha.

THE COURT: Okay.

MR. SMOLEN: Bob was part of our community, okay? You guys are part of this community. We've been funding this. We pay them with tax dollars. It's our money. And then they're going to come here and tell us it's not the corporation, the corporation that we paid $41 million of our money to provide care to the people in our community who happen to be incarcerated pending their trials.

Ms. Young was in there because she had been sentenced. She was pending an appeal. Her case was totally reversed, it was totally dismissed, she would have never been in jail, seven months after she died. She had no -- she has no prior

convictions. They can't say anything bad about her. They want to try to insinuate that she was like a bad person because she had been in the jail and that somehow because she was in the jail her life is worth less than ours. I think that's totally disgusting.

Do you know who she was? She was a grandmother of 15 kids. She had three kids that she had raised. She made sure one of them became an ICU nurse, the other one owns a trucking company, and the other one's in beauty school. That's who she was.

I feel like they're coming down here like literally stealing our money and laughing at us. They don't put any witnesses on to explain it. He wants to stand up here and talk about NCCHC and that they're the gold standard. Well, where are they? Why didn't they come and tell you how great everything was at CHC? Why don't they have Dr. Herr come down here and explain why no one was following the promises that he had made in 2012? Because they don't have a single person that will testify that this was a safe, constitutionally-sound system. That's why their case in chief was the medical examiner that nobody disagreed with. That's what they had.

The main defenses in this case that I've heard are, you can't believe Tammy Harrington even though she's making contemporaneous notes and reporting this up the chain to the executives because she got fired from a couple jobs after the

fact, right? Total disregard it, that's what they're saying. But we want you to believe Karen Metcalf, who has repeatedly falsified vital signs. We want you to believe Karen Metcalf, who never received training. We want you to believe Karen Metcalf, who lied on her employment application, saying that she had never been terminated from a job, when, in fact, she had been terminated by CHC in 2006. She doesn't put down the other terminations in her employment application. It's Plaintiff's Exhibit 35. Take a look at it. She lies about her employment history, but they want you to rely on her like her word's good.

Chris Rogers, she doesn't even remember the video of Elliott Williams. She just got to resign from her job. She testified no one received any discipline for any of the conduct. Like that is crazy. The fact that the defense lawyer wants to bring up with Captain McKelvey that the FBI maybe or maybe didn't file charges for committing crimes, that that somehow makes it our system is okay, that's their defense?

They want you to believe Dr. Adusei, right? Dr. Adusei was injecting patients at the jail in their jugular vein with saltwater placebo because he thought they were faking mental health issues. I didn't make that up. His own physician co-worker reported him to the sheriff's office. That's crazy that that was allowed to happen. That was happening three months after they had promised the county they would fire him,

and they still allowed him to continue to work for an entire year.

He doesn't see Gwendolyn Young for an entire year. So like the defense is, well, if I just don't see them, how would they prove that I knew that they were sick? Well, he's required to review the charts daily. He's required to do rounds on inmates in the SHU. He's required to do rounds on inmates in the infirmary. He's required to chart it. He's required to document it. That's how he should know.

Hey, Charlie, let's pull up Plaintiff's Exhibit 44, page 12.

This part really bothered me about the closing and I do want to address it. This idea that you wouldn't take a person to the hospital just because they're vomiting, like he totally disregards the blood pressure of 80, totally disregards the shortness of breath, totally disregards the chest pain, totally disregards the fact that she can't even walk on her own, okay, totally disregards the fact that she's been laying on the floor for four days. It's just that she's been vomiting, folks.

Charlie, take them down a little bit in that to -- there.

This is Dr. Adusei's note when he first responds, okay? He says that it was difficult to access the airway. There were a lot of soft tissue swelling and vocal cords could not easily be seen.

She had been vomiting so profusely for such a long period of time that they couldn't even intubate her when they found her. That's how swollen her throat was. That is so wrong on so many different levels.

He goes up at 9:47. He says that's when he got called.

Take it up a little bit, Charlie.

This is so important that you understand it. I mean, it's just one of the pieces but I think it's just so disgusting. If you look at Defendant's Exhibit 2, okay -- is it 2, Bryon, or 50?

MR. HELM: 50.

MR. SMOLEN: 50. Defendant's Exhibit 50. Okay. It shows that Dr. Adusei was called 28 minutes before he actually arrived, okay? He kind of tried to blame it on like the jail setup.

I will tell you that if you watch Defendant's Exhibit -- the videos of Ms. Young. DX 62? Or PX 73, okay, it takes two minutes and 29 seconds for them to wheel Ms. Young from the cell in the SHU to the infirmary, two minutes and 29 seconds. You don't have to take my word for it. Watch the video. That's because the SHU is at the north end of the hall where there's two doors that open.

He sat in his office for half an hour --

MR. CHAPMAN: Objection, Your Honor. There's no

testimony he sat in his office.

THE COURT: Sustained. It's the evidence that you recall hearing at trial.

MR. SMOLEN: He was two minutes away at most to go check on her. He says, this was the best we could do based on our resources. We're going to let her vomit for four days until the point where her throat is so swollen we can't intubate, I'll wait half an hour to go see her when the nurse comes in and tells me she's nonresponsive, not breathing, but Nurse White says she was faking.

MR. CHAPMAN: Objection, Your Honor. There's no testimony that the nurse came in to tell him anything.

THE COURT: Sustained.

MR. SMOLEN: Quote -- since there's no evidence -- I was called by the nursing staff for a medical emergency regarding this patient at around 9:47 a.m.

I'll just rely on his own note as evidence, okay, because that's what happened. To let her lay there on the floor for 28 minutes and to act like there was something about the physical structure of the jail that prevented him from getting there, when you could watch the very video of Ms. Young being wheeled down the hall, is totally wrong. It is hard for me to watch someone do that to a jury. The evidence is in front of you. Look at it. You don't have to believe me. You have all the evidence that you'll need to determine that.

Cut to trial transcript 1303, lines 16 through 22. I want to show the jury this.

This was a question that you guys asked him. And, I mean, look, I've never, ever had a case -- and I've been doing it for two decades -- I've never had a case where a judge let's the jury write questions. In fact, in most of my cases, in my openings and in my closings, I tell the jury this is a very weird process, me having to ask questions and you guys never getting to know -- you know, if you've got questions and me never knowing that you had questions. It's a hard way to communicate with people, the question-and-answer format, right? This is the first time in my entire career that a judge allowed you guys to write questions and I thought it was really amazing that that happened. I mean, I really truly appreciate that because I've never seen it. I thought it was amazing to know where you guys were coming from. Some your questions were so pointed it probably could have got the case done, if you guys were asking the questions, only in about three or four days. But it was reality nice to have it, okay?

But you asked this question about, did he feel prepared as the medical director. And he says, "Now, with respect to jail care, I don't know. I did the best I could based on my training. Jail care requires different things it, right? You have to worry about security at all times, you know. You go into this room, you can't go into that room, and you have to

wait for an officer to come. Things are a little different. Was I prepared for it? I don't know."

That's what he said. He wasn't. He had been asked to leave his residency at OU. He took the first job that he could get. He was supposed to be terminated by May 30th of 2012 but they let him stay on. They let him stay on providing completely deficient care, continuing to ignore inmates, despite repeated complaints from his co-workers. And when Ms. Young was housed in the SHU, he never saw her, he never reviewed her charts, he never did anything. That's deliberate indifference. It's very simple. If, at any point in time, anyone had done anything to help her, get her to the hospital, she would be here, but they didn't.

They kept saying, look, we did some good things. That's a good thing. CHC, we put a cuff on her arm. The reality of it was they took no action when she had high blood pressure and had drastic blood pressure drops which should have triggered transfer to a hospital per their own policy, okay? That's what happened.

It was a good thing that we took her to the infirmary, right? That's what they said. It's a good thing to take her to the infirmary. Reality: They tried to drag her on the ground like an animal that couldn't move or walk to the infirmary on a blanket until the guard said no more. That's the reality.

They said, CHC giving meds is a good thing, to give medication is a good thing. Reality: They continued to give Ms. Young Advil and high blood pressure medication despite the fact that she had a subdural hematoma, had all the symptomatology of it, and she had a blood pressure below 100. That's not a good thing.

Look, we heard Gwendolyn's daughter, Deborah, testify about what they wanted to and how they wanted to use this money to do a foundation. That's great. But that's not what damages are for. With all -- it's not when we're talking about compensatory damages, okay?

Compensatory damages are about what Gwendolyn went through, right? In a constitutional case, we're not talking about her pain and suffering. We're not talking about the grandkids' pain and suffering from not getting to see their grandma. We're talking about Gwendolyn being deprived of those things through her constitutional rights being violated. It's that she is missing seeing these grandkids go to prom.

My kid recently had a homecoming and he's a freshman --

MR. CHAPMAN: Your Honor, again, his personal experiences of his children are not relevant here.

THE COURT: Sustained.

MR. SMOLEN: -- and it was -- seeing him with his friends --

MR. CHAPMAN: Objection, Your Honor. You sustained

the objection.

THE COURT: Sustained.

MR. SMOLEN: Our whole community is affected by this, guys. Look at the evidence.

PX 41, subpage 2, if you can get there real quick.

She is reporting to the jail staff and the medical staff for days, okay, that she wants to go to the hospital. She's begging to go to the hospital. She knows she's sick. Deborah talked about how scared she looked. She knows her better than anybody, okay? In all the documentation, it's just over and over.

Guys, it's really scary to think that someone can lay in a cell for days while people stand over them, like in the Elliott Williams video, like in Gwendolyn's death, and they're like laying there and they're just like, help. But like no one's listening to them and no one's believing them. Like that's terrifying. That's a terrible way to die. That is just a slow death where you're just laying there day after day telling people, I need help, and no one's doing anything until you can't even walk anymore.

That's this company. That's this company who took $41 million from us and did that to those people.

Look, I can't tell you more honestly than I've told you how urgent this situation is. They came down here with no witnesses because they don't think you guys care about people

who are in jail. That's why they don't even have a defense. It's like they're laughing at us, they're taking our money, because they don't think anyone's going to stop them from doing it and I think it's so, so wrong.

If you don't think this case is about money, that's what it's about. They got $40 million. They had a financial incentive not to send people to the hospital. It's in the contracts, all the contracts. They're the largest private health-care provider in corrections in the entire United States.

MR. CHAPMAN: Objection, Your Honor. There's no testimony, there's no proof of that.

THE COURT: Sustained.

MR. SMOLEN: They filed tax filings last year --

MR. CHAPMAN: Objection, Your Honor. Tax filings are not relevant.

THE COURT: Sustained.

MR. SMOLEN: Look --

THE COURT: Can we have a quick sidebar, please?

MR. SMOLEN: Yep.

THE COURT: Thank you.

(Bench conference)

THE COURT: We're in rebuttal. Please don't tank this case now.

MR. SMOLEN: I understand. I'm sorry.

(Bench conference concluded)

MR. SMOLEN: One of the reasons that these cases are so important is because of the deterrent effect that a jury can have on the system. Like you don't have to do it through legislation. You don't have to do it through Congress. You can do it today. You can be the first people that say we're not going to accept this, right, a jury in Tulsa, Oklahoma. You guys can be the first to send an historic verdict that says this is not okay. It's not okay.

He's up here talking about hundreds of millions of dollars. The reason why he's doing that is because he knows --

MR. CHAPMAN: Objection, Your Honor. I'm not talking about hundreds of millions of dollars.

THE COURT: Sustained. Sustained. Sustained.

MR. SMOLEN: He knows the severity of the situation and they know the overwhelming amount of evidence, and they are hoping that you guys won't do anything significant. They'll be high-fiving if you walk out of here giving a verdict of $10 or $20 million, I promise you, because that just means business as usual. They can continue to do it and they can continue to profit. That's what they want. They don't think you're going to do anything. They think they've explained it all away.

He doesn't cite to a single piece of evidence in his closing. Not one piece of evidence was cited to in his closing, not a document, nothing.

You guys need to be the first jury in Tulsa, Oklahoma, in the United States of America, to say we care about civil rights, we care about our inmates, our community should be judged by the quality of our incarcerations and the basic services that we provide, and this is not acceptable, it has to stop now. That's your obligation. That's why you're being instructed on punitive damages right now because you can deter it from happening.

The Young family wanted to put this in front of you guys. They wanted you guys to make the decision on what deterrence looked like. Because it didn't matter when NCCHC came in and they told them that they were failing. It didn't matter when the ICE auditors came in and said they were failing. It didn't matter when they videotaped Mr. Williams' death. It didn't matter when they had all the notice about all the other deaths in 2010. It didn't matter when Dr. Roemer in April of 2013 says there's still broken systems, right? It didn't matter when they promised to get rid of Dr. Adusei and then they kept him on for 13 minutes. None of it mattered to them.

That's the same way that they've presented their case. It's the same way that they've approached this. It's not the corporation's fault. It absolutely is the corporation's fault. They knew everything and they just let people in our community get tortured to death year after year with us funding it.

You have to stop it. I'm asking you to stop it. Her family is asking you to stop it.

THE COURT: Are you finished? Are you finished?

MR. SMOLEN: Oh, I'm sorry, Judge. Yes.

(The closing arguments of counsel were concluded)

C E R T I F I C A T E

I, Brian P. Neil, a Certified Court Reporter for the Northern District of Oklahoma, do hereby certify that the foregoing is a true and accurate transcription of my stenographic notes and is a true record of the proceedings held in above-captioned case.

I further certify that I am not employed by or related to any party to this action by blood or marriage and that I am in no way interested in the outcome of this matter.

In witness whereof, I have hereunto set my hand this 28th day of February 2023.

s/ Brian P. Neil

Brian P. Neil, RMR-CRR
United States Court Reporter